



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VED V. AGGARWAL, MD PA
914 LIPSCOMB ST
FORT WORTH, TX 76104

Respondent Name

AMERISURE MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-12-2253-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was originally mailed to P.O. Box 569680, Dallas, TX 75356 which is the address provided to us at the time of insurance verification 12/14/10. We were not made aware that the claims mailing address had changed to P.O. Box 33458, Detroit, MI 48232, until contacting the carrier to find out why the claim had not been paid. The provider should be reimbursed the fee schedule allowance for Texas Workers Compensation."

Amount in Dispute: \$1,025.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider has stated in the Medical Dispute Resolution that during the insurance verification process on 12/14/2010 they were given the old P.O. Box in Dallas, TX. This is correct, the new P.O. Box 33458, Detroit, MI was not given out to providers until 2/1/2011. Any bill sent to us at P.O. Box 569680, Dallas, TX would have been forwarded to the P.O. Box in Detroit. Any bill sent to us after 7/31/2011 would have been sent back to the provider. By that time, the bill would have been past the 95 day deadline anyway. As our first record of receipt of this bill is 11/4/11, we stand by our position that the bill was not timely filed."

Response Submitted by: Amerisure Insurance, P.O. Box 33458, Detroit, MI 48232

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
1/5/2011	62311, 72275-26, 77003-26	\$1,025.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated January 16, 2012

- 193-ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.

Explanation of benefits dated November 8, 2011

- 29-The time limit for filing has expired.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is 01/05/2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on 03/02/2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

_____	_____	04/13/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a *certificate of service demonstrating that the request has been sent to the other party*.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.